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Service (1)	State Plan Approved (2)	MCO/PHP Capitated Reimburse ment (4)	Fee-for- - Service Reimburse-. ment Impacted by MCO/PHP (5)	Fee-for-Service Reimburse ment for MCO/PHP (6)	PCCM Referral/ Prior Auth. Required (7)	Wraparound Service Impacted by PCCM (8)	PCCM Referral/Prior Authorization Not Required or Non-Waiver Services (9)
Rehabilitation Treatment Services	X			X			X
Respiratory Care	X	X					
Rural Health Clinic	X	X			X		
Speech Therapy	X	X			X		
Substance Abuse Treatment	X			X			X
Testing for Sexually Transmitted Diseases	X	X					
Transportation - Emergency	X	X			X		
Transportation - Non-emergency	X	X			X		
Vision Exams and Glasses	X		X				X

Mandate

1. In the NHC program, Nebraska will enter into contracts with State licensed MCOs. Nebraska will enter into comprehensive risk contracts with. the MCOs. These organizations will arrange for comprehensive services, including inpatient or outpatient hospital, laboratory, x-ray, physician, home health, early periodic screening, diagnosis and treatment, family planning services and all other Medicaid optional services, except for those described in Section H.1.

   All contracts will comply with Sections 1932 and 1903(m) of the Act. All contracts Nebraska has selected the MCOs that operate under the NHC program in the following manner: Nebraska has used and will use an open cooperative procurement process, in which any qualifying MCO that complies with federal procurement requirements and 45 CFR Section 74 may participate. The Department requires all participating MCOs to be licensed by the Nebraska Department of Commerce, Insurance Division. This licensure also identifies the MCO service area, by county in the state. The Department sets the capitation rates by region in the state and any participating MCO must accept those rates for the respective Medicaid covered

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services.

2. With respect to the PCCM, the contracts Nebraska enters into with PCPs will contain (at a minimum) all terms required under section 1905(t)(3). Reimbursement will be made on a fee-for-service basis, with a $2.00 monthly case management fee for each PCCM recipient assigned. The following is a list of the types of providers that qualify to be primary care providers under the NHC program: physicians (pediatricians, family practitioners, internists, general practitioners, obstetrician/gynecologists).

   Certified nurse practitioners are not included as a PCP type; however these services will be made available: The Department covers these services in the same manner as fee-for-service. The only difference is that a referral from the PCP provider is required for reimbursement of the services. Any Nebraska Medicaid provider of this type is able to see and treat a NHC recipient with the required referral.

   Nurse midwives are not included as a PCP type, however these services will be made available: The Department covers these services in the same manner as under fee for service. The only difference is that a referral from the PCP is required for reimbursement of the services. Any Nebraska Medicaid provider of this type is able to see and treat a NHC recipient with the required referral.

3. All participating PCPs in the PCCM shall be required to sign a PCCM participation agreement in addition to the standard Medicaid provider agreement and shall be bound by its terms and conditions. Each PCP shall be required to specify the number of recipients the PCPs willing to serve as primary care physician in a number not to exceed the number set forth in Title 482 NAC.

4. PCP under the NHC program must:

   a. Be Medicaid-qualified providers and agree to comply with all applicable federal statutory and regulatory requirements, including those in Section 1932 of the Act and 42 CFR 434 (and new requirements in 42 CFR 438 when final) and all State plan standards regarding access to care and quality of service;

   b. If participating in a PCCM sign a contract or addendum for enrollment as a PCP which explains the PCP's responsibilities and complies with the PCCM contract requirements in Section 1905(t)(3) of the Act including: making available 24-hour, 7 days per week access by telephone to a live voice (an employee of the primary care case manager or an answering service) or an answering machine which will immediately page an on-call medical professional for information, referral, and treatment of medical emergencies; referrals for non-emergency services; or to information about accessing services or how to handle medical problems during non-office hours;

   c. Provide or arrange for the provision of comprehensive primary health care

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services to all eligible Medicaid beneficiaries who choose or are assigned to the PCP's practice;

d. Refer or have arrangements for sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

e. Have hours of operations that are reasonable and adequate. The PCP must have the same hours of operation for the NHC enrollees as they have for their other patients. The Department requires all PCP's to have 24-hour access via telephone. This does allow for another provider to be on-call for the PCP provider during non-office hours.

f. Not refuse an assignment or disenroll an enrollee or otherwise discriminate against an enrollee solely on the basis of age, sex, race, physical or mental handicap, national origin, or health status or need for health services, except when that illness or condition can be better treated by another provider type;

g. Not have an affiliation with person debarred, suspended, or otherwise excluded from federal procurement activities per Section 1932(d)(1) of the Act;

5. Qualifications and requirements for PCPs are noted in the provider agreements. MCOs and PCCMs shall meet all of the following requirements:

a. An MCO shall be a Medicaid-qualified provider and agree to comply with all pertinent Medicaid regulations and state plan standards regarding access to care and quality of services.

b. The MCO shall sign a certification agreement that explains the responsibilities MCOs must comply with.

c. The MCO shall have a state-approved grievance and appeal process.

d. The MCO or PCCM PCP shall provide comprehensive primary health care services to all eligible Medicaid recipients who choose, or are assigned to, the MCO or PCCM Program.

e. The MCO or PCCM PCP shall refer enrollees for specialty care, hospital care, or other services when medically necessary.

f. The MCO or PCCM shall make available 24-hour, 7-day-a-week access by telephone to a live voice (an employee of the MCO or a representative or a representative of the PCCM) or an answering machine which will immediately direct an enrollee as to how to contact an on-call medical professional, so that referrals can be made for non-emergency services and information can be given

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g. The MCO or PCCM shall not refuse an assignment, disenroll a participant, or otherwise discriminate against a participant solely on the basis of age, sex, physical or mental disability, national origin, or type of illness or condition, except when that illness or condition can be better treated by another provider type.

h. The MCO or PCCM may request reassignment of the participant to another MCO or PCCM only if the patient/provider relationship meets the provisions set forth in Title 482 NAC. All reassignments must be state-approved.

The Department reviews all reasons for transfer on a quarterly basis via the reports from the enrollment broker. The Department meets with the enrollment broker weekly to review all current issues, including any requests for disenroliment by any PCP, PCCM or MCO.

i. All MCO and PCCM subcontractors shall be required to meet the same requirements as those that are in effect for the contractor.

j. The MCO shall be licensed by the Division of Insurance in the Nebraska Department of Commerce in order to ensure financial stability (solvency) and compliance with regulations.

k. Access to medically necessary emergency services shall not be restricted. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

l. Nebraska ensures enrollee access to emergency services by requiring the MCO/PCCM to provide adequate information to all enrollees regarding emergency service access.

m. Nebraska ensures enrollee access to emergency services by including in the contract requirements for MCOs/PCCMs to cover the following.

(1) The screening or evaluation and all medically necessary emergency services, when an enrollee is referred by the PCP or other plan representative to the emergency room, regardless of whether the prudent layperson definition was met,

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(2) The screening or evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,

(3) Both the screening or evaluation and stabilization services, when a clinical emergency is determined,

(4) Continued emergency services until the enrollee can be safely discharged or transferred,

(5) Post-stabilization services that are pre-authorized by the MCO or primary care case manager, or were not pre-authorized, but the MCO or the primary care case manager failed to respond to request for pre-authorization within one hour, or could not be contacted. Post-stabilization services remain covered until the MCO or primary care case manager contacts the emergency room and takes responsibility for the enrollee.

J. Additional Requirements

1. Any marketing materials available for distribution under the Social Security Act, state statutes and regulations shall be provided to the Department for its review and approval.

2. The MCO shall certify that no recipient will be held liable for any MCO debt as the result of insolvency or for services Nebraska Medicaid will not pay for.

3. The MCO shall include safeguards against fraud and abuse, as provided in state statutes.

4. The MCO shall allow the state to take sanctions as prescribed by federal or state statutes. Also, the MCO shall provide assurance that due process will be provided.

K. FQHC and RHC Services

The program is mandatory and the enrollee is guaranteed a choice of either a PCP employed or contracted with an FQHC as a PCP or at least one MCO/PCCM which has at least one FQHC as a participating provider.

All of the FQHCs in the state are participating in the PCCM program. This allows any recipient to be able to select a PCP employed or contracted with an FQHC as the primary care case manager. In addition, the MCO contract specifically mentions the encouragement to contract with FQHCs in the service area. FQHC reimbursement will follow all applicable federal requirements. The MCOs must pay FQHCs and RHCs rates comparable to non-FQHC and RHC providers. Nebraska State Medicaid Plan provides for the prospective payments to FQHC's and RHC's.

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L. Quality of Health Care and Services, Including Access

1. Nebraska requires all MCOs and providers, by contract, to meet state-specified standards for internal quality improvement programs (QIPs).

2. On a periodic or continuous basis, Nebraska monitors the adherence to these standards by all MCOs, through the following mechanisms:

   a. Review of the written QIP for each MCO to monitor adherence to the Nebraska QIP standards. Such review shall take place at least annually.

   b. Periodic review of numerical data or narrative reports describing clinical and related information on health services and outcomes of health care for the Medicaid enrolled population. This data will be submitted to the Department as required by the contract with the MCO.

   c. Monitoring of the implementation of the QIP to ensure compliance with Nebraska QIP standards. This monitoring is conducted on-site at both the MCO administrative offices and the care delivery sites, as necessary. At least one such monitoring visits shall occur per year.

   d. Monitoring through the use of Department personnel and contracted staff.

3. The Department will arrange for an independent, external review of the quality of services delivered under each MCO's contract with the state. The review will be conducted for each MCO contractor on an annual basis. The entity which provides the annual external quality reviews shall not be a part of the state government, an MCO, or an association of any MCOs.

4. Recipient access to care will be monitored as part of each MCO's internal QIP and through the annual external quality review for MCOs. The periodic medical audits, state monitoring activities and the external quality review shall all derive the following information:

   a. Periodic comparisons of the number and types of Medicaid services before and after the institution of the NHC Program.

   b. Recipient satisfaction surveys managed by state staff.

   c. Periodic recipient surveys which the MCOs will conduct containing questions about recipient access to services.

   d. Measurement of waiting periods to obtain health care services; including standards for waiting time and monitor performance against these standards.

   e. Measurements of referral rates to specialists.

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Citation			
42 CFR 435.914 1902(a)(34) of the Act	2.1(b)	(1)	Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.
1902(e)(8) and 1905(a) of the Act		(2)	For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month which the individual is first determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.
1902(a)(47) and	_____	(3)	Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.

42 CFR 438.6

(c) The Medicaid agency elects to enter into a risk contract that complies with 42 CFR 438.6, and that is procured through an open, competitive procurement process that is consistent with 45 CFR Part 74. The risk contract is with (check all that apply):

___ Qualified under Title XIII 1310 of the Public Health Service Act.

_X_ A Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2.

___ A Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2.

___ A Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2.

___ Not applicable.

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Agency*	Citation(s)	Groups Covered
1932(a)(4) of Act		B. Optional Groups Other Than the Medically Needy (Continued)

The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56.
This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

___ Disenrollment rights are restricted for a period of ____ months (not to exceed 12 months).

During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

_X_ No restrictions upon disenrollment rights.

1903(m)(2)(H), 1902(a)(52) of the Act
P.L. 101-508
42 CFR 438.56(g)

In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to re-enroll those individuals in the same entity if that entity still has a contract.

_X_ The agency elects to re-enroll the above individuals who are eligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.

___ The agency elects not to re-enroll above individuals into the same entity in which they were previously enrolled.

* Agency that determines eligibility for coverage.

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f. Assessment of recipient knowledge about how to obtain health care services:

g. Utilization and encounter data submitted by MCOs.

M. Access to Care.

Nebraska assures that recipients will have a choice between at least two PCCM PCPs or a combination of one MCO and the PCCM program.. When fewer than two choices are available in the geographic area, the managed care program is voluntary. In addition to this process, the NHC program is not likely to substantially impair access because of the following:

1. Recipients may choose any of the participating MCOs or PCCM PCPs in the service areas. In addition, as per 42 CFR 434.29, within an MCO each Medicaid enrollee has a choice of health professional to the extent possible and feasible.

2. The same range and amount of services that are available under the Medicaid fee-for-service program are available for enrollees covered under the NHC Program.

3. Access standards for distances and travel miles to obtain services for recipients under the NHC program have been established. Specifically, the NHC program must have a PCP within 30 miles or 30 minutes.

   The Department utilizes the 30-mile/30-minute guideline for all NHC providers. This is applied to the MCOs at the time they request service to a new county, as well as quarterly thereafter. The Department requires the enrollment broker to review each county for PCP access on a quarterly basis in the PCCM program. This report is submitted to the Department for review.

   The Department realizes that there are rural portions of the state that simply do not have certain specialists within a 30-mile/30-minute radius. In. the event of MCO or PCCM expansion, the external quality review organization will review the specialist panel for adequacy. This is based on a knowledge of the existing pool of specialists and whether there are a sufficient number of specialists in the panel of the MCO to service the enrollment level of the area.

   The PCCM option allows the PCP to give a referral to any Nebraska Medicaid. provider, thus the panel of specialists would be the entire Nebraska Medicaid provider network. This allows any PCCM enrollee to see any specialist that accepts Nebraska Medicaid. Therefore, this network is no less than the network available to a person not in the NHC program.

   The Department realizes that there are some counties in the state that do not have a hospital. While the normal guideline is to have at least one hospital in the county being served, consideration is given to those counties without a hospital.

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Additionally, if a county has multiple hospitals, the Department expects to see a fair representation on the provider network.

4. The number of providers to participate under the NHC program is expected to increase.

5. Primary care and health education are provided to enrollees by a chosen or assigned MCO or PCCM PCP. This fosters continuity of care and improved provider/patient relationships.

6. Pre-authorization is precluded for emergency care and family planning services under the NHC Program.

7. Recipients have the right to change plans at any time if good cause is shown.

8. MCOs and PCCM PCPs are required to provide or arrange for coverage 24 hours a day, 7 days a week.

9. Recipients have available a formal appeals process under 42 CFR Part 431, Subpart E. The same appeals hearing system in effect under the Medicaid fee-for-service program is in effect under the NHC program pursuant to Title 467 NAC.

10. Nebraska assures that state-determined access standards are maintained by quarterly analysis of provider panels.

11. Under the terms and conditions of their existing contracts, MCOs must:

    a. Assure that covered services are accessible to all enrollees, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, and with physical or mental disabilities.

    b. Provide to enrollees and prospective enrollees: an informational letter written in the applicable language explaining the MCO policies, a toll-free number to obtain further information about the MCO in the applicable language, all enrollment materials written in the applicable language, and translation services when necessary to ensure delivery of covered services.

    c. Inform a non-English-speaking enrollee about any provider who speaks the same non-English language, if the MCO is aware of any such provider.

12. Nebraska has a limit in Title 482 NAC on the number of recipients that can be managed by a physician in the NHC program in effect under the NHC program. The limit guarantees access to appointments within acceptable time parameters for urgent and illness-related conditions as well as non-symptomatic preventive care. The number of Medicaid recipients also allows for the PCP to serve a sufficient number of private-pay and commercially insured patients to create a mixture of patients